



# EVALBRIEF: SYSTEMS OF CARE

February 2005

Volume 6, Issue 5

## Medicaid, Limited Access to Insurance, and Receipt of System-of-Care Services

### Introduction

In recent years, many State governments have faced a crisis financing their mental health services, due largely to the decreasing availability of resources to meet their State's demands. Medicaid, as a result, has assumed a greater share of the financing of mental health services (Congressional Quarterly Inc., 2004). In fact, Medicaid now finances half of all spending on public mental health systems (Koyanagi et al., 2003; Koyanagi & Semansky, 2003).

The implications of this shift in responsibility might be significant for non-Medicaid recipients. This *EvalBrief* examines findings that describe the relationships between limited access to insurance, Medicaid eligibility status, and families' receipt of needed mental health and physical health services.

### Findings

Many non-Medicaid recipients are eligible for Medicaid but are unaware of their eligibility status; accordingly, they have limited means to pay for both physical health care and mental health care services. This phenomenon is prevalent among many families whose children enroll in the system of care. During intake into services, 60.5% of families report earning incomes below the poverty level; however, only 83.8% of these families report being eligible for Medicaid. This leaves 16.2% of families who live below the poverty level and do not report being eligible for Medicaid.

### Study Highlights

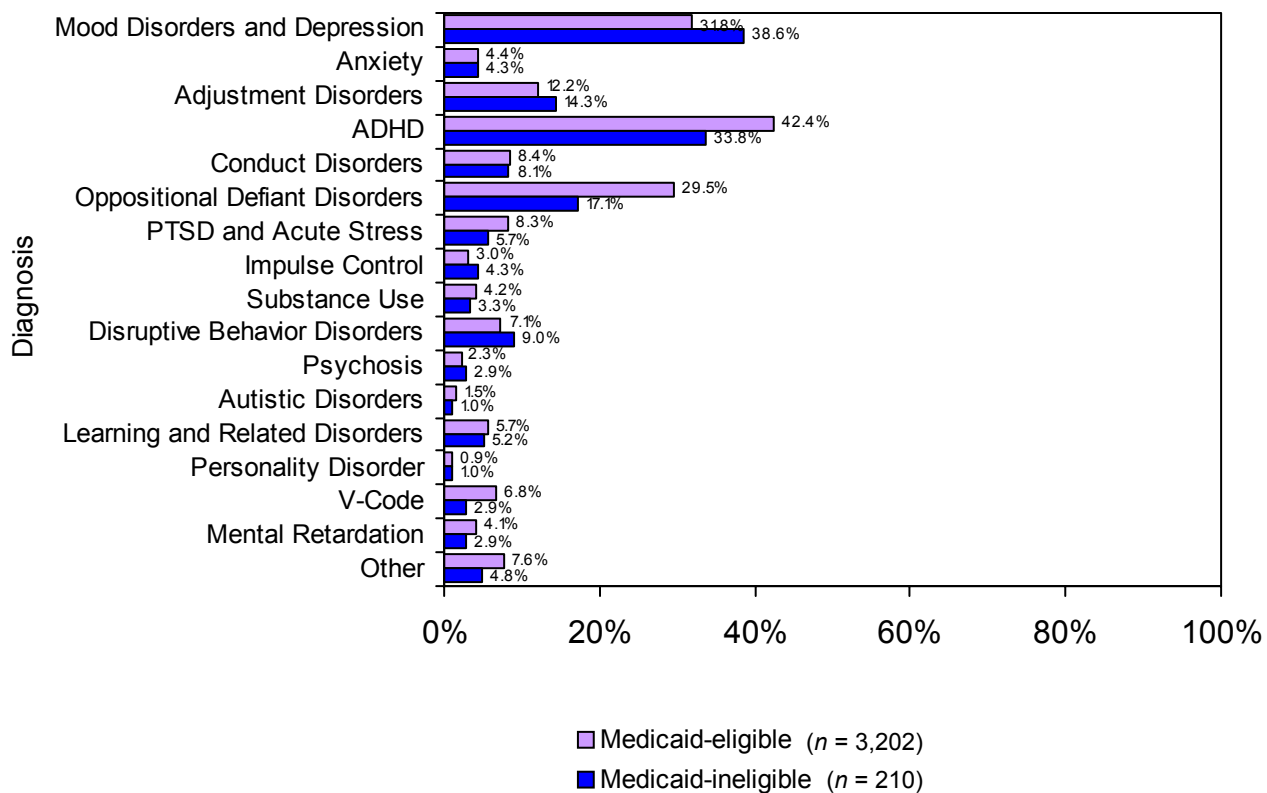
- ▶ ***Medicaid has assumed a greater share of the financing of mental health services in States, currently financing half of all spending on public mental health systems.***
- ▶ ***Many families whose children enroll in systems of care are non-Medicaid recipients eligible for Medicaid but unaware of their eligibility status; therefore, they have limited means to pay for both physical and mental health care services.***
- ▶ ***Nearly half of families living below the poverty level who at intake reported being ineligible for Medicaid, identified themselves as Medicaid-eligible after 6 months of enrollment in systems of care.***
- ▶ ***Given Medicaid's substantial role in financing mental health services, linking youth enrolled in systems of care and their families to Medicaid might be a critical way to sustain access to mental health services beyond enrollment in systems of care.***

While eligibility criteria for Medicaid and SCHIP (State Children’s Health Insurance Plan) vary by State, requirements typically include an income below the poverty level and children residing in the home. Therefore, the 16.2% of families who report that they are ineligible for Medicaid, but also report that they live below the poverty level, are most likely unaware that they qualify for Medicaid. The result is that these families are more likely to pay out of pocket for their children’s health care. In fact, the data show that 33.4% ( $n = 329$ ) of these families reported paying for at least part of their services compared to the 5.6% ( $n = 4,361$ ) of families living below the poverty level who report being Medicaid- and SCHIP-eligible.

When families have limited access to health insurance, they often encounter difficulties paying for their children’s health care needs.

Socioeconomic status alone did not account for a perceived inability to pay for health care needs. Rather, the combination of living below the poverty level and being ineligible (or being unaware of eligibility) for Medicaid accounted for an inability to pay for health care services. This finding is apparent from caregivers’ direct reports on measures such as the Family Resource Scale. (The remainder of the report will use the terminology “Medicaid-eligible” to refer to families living below the poverty level who reported being eligible for Medicaid or SCHIP at the time of intake into services. In contrast, the term “Medicaid-ineligible” will refer to families living below the poverty level who reported not being eligible for Medicaid or SCHIP at the time of intake into services, regardless of whether in actuality they qualify.) Just over 20% of Medicaid-ineligible families reported that resources were “not at all adequate” for their

**Figure 1**  
**Clinical Diagnosis on Any Axis at Intake**



family's medical care, which was significantly greater than the 5% of Medicaid-eligible families reported ( $\chi^2 = 70.2$ ,  $df = 4$ ,  $n = 2,551$ ,  $p < .001$ ). Conversely, a much larger proportion of Medicaid-eligible families reported that resources were "almost always adequate," 58.7% ( $n = 2,354$ ) of Medicaid-eligible families compared to 43.1% ( $n = 197$ ) of Medicaid-ineligible families.

The relationship between access to health insurance and access to health care becomes apparent when examining Medicaid-ineligible families' difficulty accessing health care. Axis IV on the *DSM* (American Psychiatric Association, 1994) is used to report environmental and psychosocial factors that may influence youth's diagnosis and treatment. A little over 18% of Medicaid-ineligible families were identified as having problems accessing health care, as measured by Axis IV on the *DSM*. This percentage is significantly higher than the 3.6% of Medicaid-eligible families ( $\chi^2 = 79.8$ ,  $df = 1$ ,  $n = 2,604$ ,  $p < .001$ ) and 4.2% of families overall who were similarly diagnosed. This disparity in access could become a growing trend as Medicaid bears a greater portion of financing mental health costs.

Perhaps the effect of being uninsured would be less considerable if Medicaid-ineligible youth

experienced fewer physical and mental health problems. These youth, however, report as many, if not more, health problems than Medicaid-eligible youth. Slightly more Medicaid-ineligible youth experience limitations in their activities due to physical health problems (47.0%) than their Medicaid-receiving counterparts (40.0%), even though the difference in activity limitation was not statistically significant ( $\chi^2 = 2.45$ ,  $df = 1$ ,  $n = 1,094$ ,  $p > .05$ ).

Furthermore, Medicaid-ineligible youth seem to experience greater severity in activity limitations. Their activities were disrupted, on average, 12.2 ( $n = 111$ ) times in the 6 months prior to intake into the system of care in comparison to the 8 ( $n = 983$ ) times of activity disruption reported by Medicaid-eligible youth. In addition, a similar proportion of Medicaid-ineligible youth reported suffering from chronic conditions as Medicaid-eligible youth (35.6% and 40.0% respectively) ( $\chi^2 = 2.45$ ,  $df = 1$ ,  $n = 4,716$ ,  $p > .05$ ). The clinical diagnoses of Medicaid-eligible youth and Medicaid-ineligible youth also seem to be similar. Figure 1 presents the pattern of clinical diagnoses of these youth at intake.

Despite limitations in finances, Medicaid-ineligible families were finding a means to pay for some of the services their children need.

**Table 1**  
**Physical Health Services Used by Medicaid-Eligible and Medicaid-Ineligible Youth**

Physical Health Service	Medicaid-Eligible	Medicaid-Ineligible
Number of times saw a doctor	$M = 2.24$ ( $SD = 4.32$ )	$M = 3.07$ ( $SD = 9.17$ ) <sup>a</sup>
Number of ER visits	$M = 0.41$ ( $SD = 1.28$ )	$M = 0.43$ ( $SD = 1.15$ )
Times hospitalized	$M = 0.09$ ( $SD = 0.52$ )	$M = 0.18$ ( $SD = 0.55$ ) <sup>b</sup>
Number of days hospitalized	$M = 10.04$ ( $SD = 19.35$ )	$M = 5.43$ ( $SD = 5.75$ )
Number of times experienced other health problems	$M = 2.72$ ( $SD = 5.44$ )	$M = 2.25$ ( $SD = 2.49$ )

<sup>a</sup>  $t = 1.66$ ,  $df = 1,111$ ,  $p < .01$ .

<sup>b</sup>  $t = 1.56$ ,  $df = 1,132$ ,  $p < .01$ .

Caregivers reported that their children are using health care services, albeit in slightly different amounts and with variations in types of services than those received by Medicaid-eligible youth. Table 1 presents the average amount and type of service used by Medicaid-ineligible and Medicaid-eligible youth at intake into the system of care. The results indicate that Medicaid-eligible and Medicaid-ineligible youth vary significantly in terms of number of times they have seen a doctor and the number of times hospitalized.

Interestingly, enrollment in the system of care links many families to Medicaid and/or SCHIP. Nearly half of families living below the poverty level who at intake reported being ineligible for Medicaid, identified themselves as Medicaid-eligible after 6 months of enrollment in the system of care (48%,  $n = 277$ ). This finding is not related to a reduction in income; in fact, the average income for these families increased between intake and 6 months.

The effect of having access to insurance is highlighted by the change in these caregivers' reports after 6 months of services, particularly on items relating to problems paying for children's health care. The percentage of families who reported having resources "not at all adequate" for financing their families' medical care decreased from 9.6% to 5.7% ( $n = 53$ ); and the

number who reported that resources were "almost always adequate" increased from 42.3% to 52.8% ( $n = 53$ ).

## Conclusion

As Medicaid assumes a greater portion of the financing of mental health, systems of care will need to consider the implications for youth who are not Medicaid recipients, particularly those from low-income families with few resources available for health insurance. Given Medicaid's substantial role in financing mental health services, linking youth and their families to Medicaid might be a critical way to sustain access to mental health services beyond enrollment in systems of care.

## References

- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Koyanagi, C., Mathis, J., et al. (2003). *Making the right choices: Reforming Medicaid to improve outcomes for people who need mental health care* (1-17). Washington, DC: Bazelon Center for Mental Health Law.
- Koyanagi, C. and R. Semansky (2003). *No one's priority: The plight of children with serious mental disorders in medicaid systems* (1-18). Washington, DC: Bazelon Center for Mental Health Law: 1-18.
- Congressional Quarterly, Inc. (2004). The Government Performance Project: A case of neglect. *Governing*. Retrieved January 14, 2005, from <http://www.governing.com/gpp/2004>

---

### Child, Adolescent and Family Branch

Center for Mental Health Services  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health and Human Services  
1 Choke Cherry Road  
Rockville, MD 20857  
Phone: (240) 276-1980  
Fax: (240) 276-1990

*EvalBriefs* are published monthly.

For additional copies of this or other Briefs, contact:

### ORC Macro

3 Corporate Square, Suite 370  
Atlanta, GA 30329  
Phone: (404) 321-3211  
Fax: (404) 321-3688  
[www.orcmacro.com](http://www.orcmacro.com)



**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**  
Substance Abuse and Mental Health Services Administration  
Center for Mental Health Services  
[www.samhsa.gov](http://www.samhsa.gov)